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AUTHOR Scigliano, Virginia; Scigliano, John A.
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ABSTRACT

Four alternative organizational structures are discussed with regard to their applicability to the reorganization of community college allied health programs. After introductory material noting the complexities, multiple interfaces, and high costs that make allied health and nursing programs prime targets for reorganization, the four models of organization are discussed: centralized, modified centralized, collegial, and decentralized. Each model is evaluated in terms of its acceptance by personnel; validity of its objectives for the program; start-up costs; and resources required for implementation and long-term success. Examples are provided of community college allied health programs using these organizational structures, and the advantages and disadvantages of each model are set forth. Administrative issues in planning for reorganization are noted, including what functions are to be centralized, where they can be put in operation, and who will manage these functions. College operations best accomplished through centralized and collegial or shared-power structures are identified, and the issue of the policy-making role of allied health professionals is explored. Finally, suggestions for implementing a reorganization are provided, stressing the importance of specifying objectives, centralizing appropriate functions, involving staff in decision making, effecting changes slowly, and seeking a variety of viewpoints. (KL)

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Strategies for Reorganization in Allied Health and Nursing Programs: The Endless Metamorphosis

by

Virginia L. Scigliano, District Director
Instructional/Professional Development
Cuyahoga Community College

and

John A. Scigliano, Director
Center for Higher Education
Kent State University

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JC 820 284

STRATEGIES FOR REORGANIZATION IN ALLIED HEALTH AND NURSING PROGRAMS: THE ENDLESS METAMORPHOSIS

Multi-campus community college districts are faced with a host of constraints and difficult decisions in the eighties. One awesome fire-storm contraint is the demand for delivering the same level of services, and in many cases increased services, with fewer dollars and personnel. Physical plant and organizational schemes that worked in the early seventies are being revived as potential strategies to cope with the difficult times ahead--the recurring structures unfold in what looks to be an endless metamorphosis. Allied health and nursing programs that mushroomed in the seventies are especially sensitive to the coming squeeze, and more must be done now to insure their vitality in the next decade. That is why reorganization appears to be a popular treatment. The issue is whether various forms of organizational/centralization or decentralization of health programs or related functions can help solve the financial and productivity problems faced by community colleges with well developed allied health operations and the myriad systems that drive them. Can mere structural changes provide the answers to questions about survival?

Statement of The Problem

Since community colleges are bureaucracies, they reflect the typical structure of organizations that prevail in a democratic capitalistic society. Expectations are that colleges will be well managed, as much so as a bank, a business or a baseball team. But, the management components in most colleges are characterized by their relatively small size, notoriously low pay, and unrealisticly high expectations for being all things to all people. Because of this lack

of numbers in the management ranks as well as, under-capitalization, most college administrators have had to rely on their wits to do a good job of managing in their complex settings. This is usually accomplished through a zig-zag search for the "right" structure when the trustees cry for more work or the legislators signal less pay. Changing the organizational form, or "trying out" alternative structural arrangements, have surfaced as common methods of treating just about every ill colleges are prone to. What community college has not seen the traumas brought on by at least one recent massive reorganization? Most practitioners will agree that the trial-and-error mode of administrative reorganization will be with us for some time, therefore, it behooves practitioners to learn more about the alternative structures available before they launch the next edition in the endless metamorphosis.

Reorganization affects all programs and courses but probably affects no other dimension of the community college more than allied health. Allied health is relatively new on the scene; massive resources have been acquired and need constant updating, programs must be well capitalized, specialities require skilled personnel, ties between college and clinics are complex, accreditation consists of multiple interfaces and the programs must coordinate academic requirements with other disciplines offered at the college. These complexities, delicate interfaces and high costs make allied health and nursing prime targets for reorganization.

Conceptual Framework

There are basically four administrative models for organizing programs: centralized, modified centralized, collegial and decentral-

ized. Administrative structures for allied health and nursing programs span this spectrum from the highly centralized models to the decentralized models. Most programs are found somewhere in between and the "locus of control" may vary via function (See Figure 1).

INSERT FIGURE 1

Conceptually, the models reflect the theoretical framework for the college, but pragmatically, the models "set the stage" for day-to-day operation of the programs. The criteria to be utilized in evaluating these models are:

- acceptance of the model by personnel
- validity of the objectives for the programs
- start-up costs
- resources required for implementation and long-term promise of the model.

The centralized model reflects tight control at the top of the organization and places the program specialist many steps away from the decision making regarding his/her program. Colleges likely to utilize this model are those experiencing severe financial cutbacks in programs and retrenchment of personnel. The tough decisions can be made at the top, since program heads are unlikely candidates to cut their own purse strings.

As seen in Figure 2, the centralized model is viable at start-up

INSERT FIGURE 2

but has less chance for success in the other areas. Extensive research on organizations indicates that this model creates great tension among personnel throughout the organization and also results in significantly less innovation. The advantages of the model are that it enables the

college to install vehicles for monitoring cost effectivenss of programs and courses. (PPBS and zero-base budgeting are artifacts of unsuccessful attempts at using this model).

The modified-centralized model is essentially the same as the centralized but for the "release" of tension element provided by input from personnel that facilitate start-up in this model. The program objectives developed in this model are more likely to reflect "real"

INSERT FIGURE 3

program concerns. The advantages gained from personnel input may outweigh the disadvantages brought on by time delays and inter personnel conflict. This personnel input is likely to go unheralded, however, since little payoff exists for initiative or innovation.

The collegial model is a sharing of power model. This model has been found to be more successful than the others in practice. Even though there is considerable difficulty in the early stages of development because of conflict and "rolling" decisions, the long term benefits are substantial: personnel commitments, valid curriculum content, and innovation.

INSERT FIGURE 4

The decentralized model offers more hope for innovation and initiative. Control from the "top" is still possible through data gathering, evaluation, feedback, and modification of programs when appropriate. Still, this model is extremely difficult to manage and program personnel turnover can have devestating effects for the college, because highly skilled personnel cannot be replaced when they leave. The fall-out from turnover leaves knowledge gaps and discontinuity in leadership. An institution that has abundant resources,

tight span of control, and extremely talented personnel is an ideal candidate for the decentralized model.

INSERT FIGURE 5

Excellent models of centralization exist. Miami-Dade Community College, with its uncanny foresight in the sixties and seventies, developed the *Medical Center Campus designed to house all district-wide allied health and nursing programs under one roof. This single, centralized campus model has been in operation for almost a decade, and the professional staff are strong proponents of the model and its benefits.

Centralization of all health programs in a pyramidal bureaucratic structure has many advantages. There is an ease of articulation among the staff in the programs. Staff members perceive their role as integrated with the health care field. Staff and faculty reassignments are easier and duplication of laboratory facilities and other program components can be kept at a minimum. Clinical agreements can be administered centrally with efficiency and multi-accreditation requests and visits can be made more cost effective. Additionally, health care professionals can pool their expertise and keep abreast of trends and needs of the health career areas. For example, Miami-Dade's Medical Center Campus is located close to hospitals and clinics, therefore, students have greater access to training and employment placement, and college personnel work hand-in-hand (on a daily base) with professionals in nearby medical complexes. This type of centralized model (coupled with an ideal location) offers many advantages.

Researchers in sociology (Pugh 1966; Hickson 1970: Child 1976) have known for some time that larger organizations tend to be more

decentralized. The Miami-Dade case in one sense is an example of decentralization where the Medical Center Campus Vice President has considerable autonomy. From another perspective (that of location) the single "Health Careers" campus has a host of characteristics that appear in highly centralized operations: unilateral approaches to problems, massive pooling of resources, and pyramidal reporting structures. Obviously which view one takes depends on his/her frame of reference.

Drawbacks of the centralized health model include the likelihood of student and staff isolation from the college-wide mission and philosophy. College linkages can become difficult to develop and manage, particularly in the area of general education core requirements (i.e., issues can become heated as to who, where and when to offer core courses for each program). Futhermore, power blocks can develop and subgoals of the campus can substitute for what should be major college missions.

Alternatives to the centralized health model include the modified centralized model, the collegial model and the decentralized model. Probably these alternatives are closer to reality for most colleges. Few community college districts are in a position to develop new campuses, or to physically relocate all health programs to one site.

Collegial models, or sharing of power arrangements, have some characteristics of the centralized model while maintaining elements of a decentralized one as well. Hillsborough Community College (HCC) in Tampa, Florida, struggled with the issue of centralization for many years, finally opting for the collegial model due to political con-

straints and physical relocation problems. The flavor of centralization is seen in the way Hillsborough handles accreditation site visits, self studies, clinical agreements, student placement and follow-up. These functions can be coordinated either from a college-wide office or from a campus site. The collegial contribution enters at Hillsborough Community College in program planning and development, formative evaluation for decision making, and in the way changes are made on continuing basis. The collegial model is more likely than any other model to reflect the college-wide mission and objectives.

The decentralized health models characteristically have programs reporting to specific line administrators on each campus. Throughout the 70's, this model characterized Cuyahoga Community College allied health and nursing framework. The college is currently undergoing a move to the centralized model and can serve as a laboratory for the type of organizational changes discussed above. In some situations there may be a college-wide administrator to articulate intra and inter-institutionally on behalf of the programs. Advantages of the decentralized structure are that decision making is located close to expertise and rapid response can occur. Disadvantages of the model are the difficulties that arise in establishing and coordinating linkages internally with the other Health Care units. Duplication of tasks and equipment may be evident, and there may be internal articulation blocks. One obstacle in this model is the need for experienced managers that can direct the decentralized programs effectively. Both the collegial and decentralized models have more duplication of laboratories and other resources.

These different models may appear at first blush to have vary-

ing *financial advantages for a college, but the actual financial differences may be more illusions than real. Start-up costs, as well as reorganization, are often costly not only in dollars but in wear and tear on personnel. Administrators take heed that reorganization may cost more than the projected new structure will save.

The real issue confronting most administrators is more one of what to centralize and what to decentralize? The questions are:

- What functions are to be centralized.
- Where can they be put into operation.
- Who will manage these functions?

College operations that are best accomplished through a centralized framework are: self-studies, accreditation-site visits, clinical agreements, laboratory scheduling, placement, student articulation, transfer between internal programs, articulation of programs with surrounding colleges and universities, scheduling, budgeting, hiring and reassignment of staff. Decisions involving programs and courses along with decisions about the welfare of professionals may be accomplished in a collegial fashion.

The current issue of centralizing or decentralizing allied health and nursing programs reflects the more fundamental issue of whether or not allied-health personnel are to function as autonomous professionals or to be restricted to "implementation" type duties. This problem is chronic in two-year institutions and appears to be a function of the style of top administrative leadership including the leadership styles of trustees. At colleges such as Miami-Dade, where the leadership has demonstrated stability and continuity we

we see vibrant models developing. Here the centralization involves health professionals at the Vice-Presidential level, and this appears to be a viable way of making the centralized model work well.

The stability exhibited by Miami-Dade's centralized approach is not found in all operations of this type. Structural changes are occuring with far to much rapidity, and often these rapid fire reorganizations have produced a form of organizational whiplash. One must be aware that the centralized and decentralized models have both functions and dysfunctions. The task for top-level administrators is to minimize the dysfunctions in whatever structure they select. Reorganization cannot and will not eliminate the dysfunction--it will only open up a new set of dysfunctions. Those that set out to recarve a new structure for their college may want to keep the following in mind. They should:

- Specify the objectives for health programs collegewide.
- Delineate the tasks to be accomplished.
- Centralize those functions that can be better coordinated by centralization and involve staff in the decision making.
- Effect these changes slowly, as reorganization can be costly for institutions in terms of personal stress.
- Involve the staff.
- Do not underestimate professionals ability to provide expertise and quality input unthought of by top administration.

Organizational theorists have taught us that structure should

follow strategy. We can only move to improve allied health and nursing programs in any given college by taking an accurate account of the current operational strategies for programs before restructuring and at the same time keep a steady eye on the overall college goals.

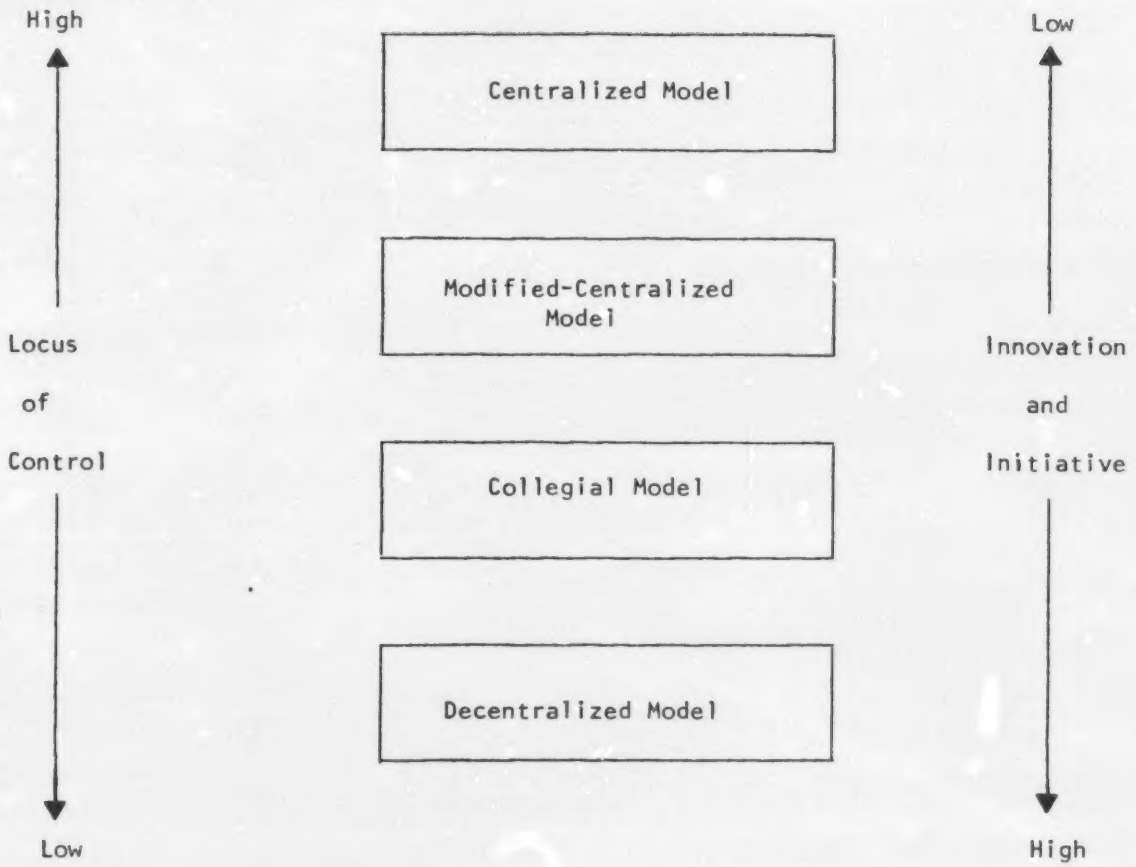


Figure 1

Conceptual Framework for Allied Health and Nursing Program, Models of Structure.

Figure 2

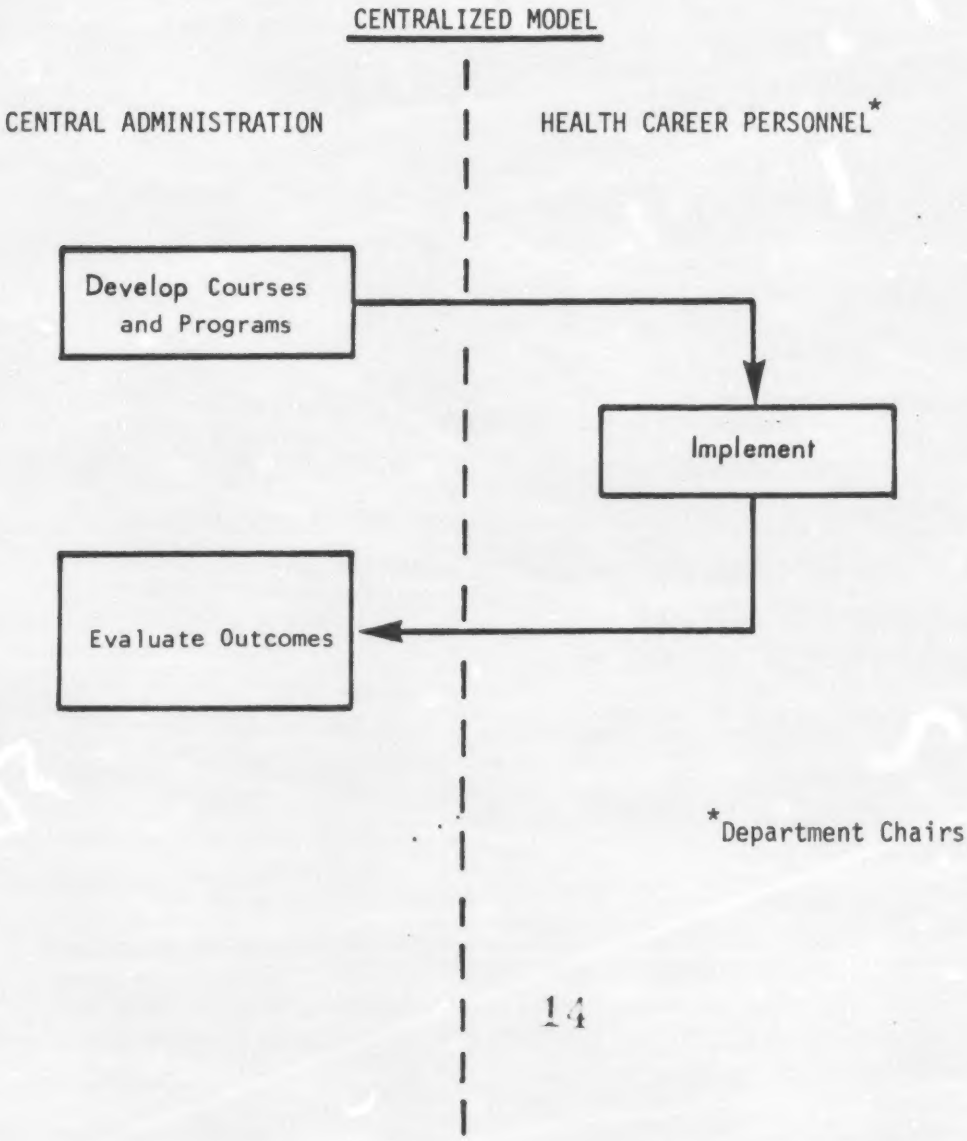
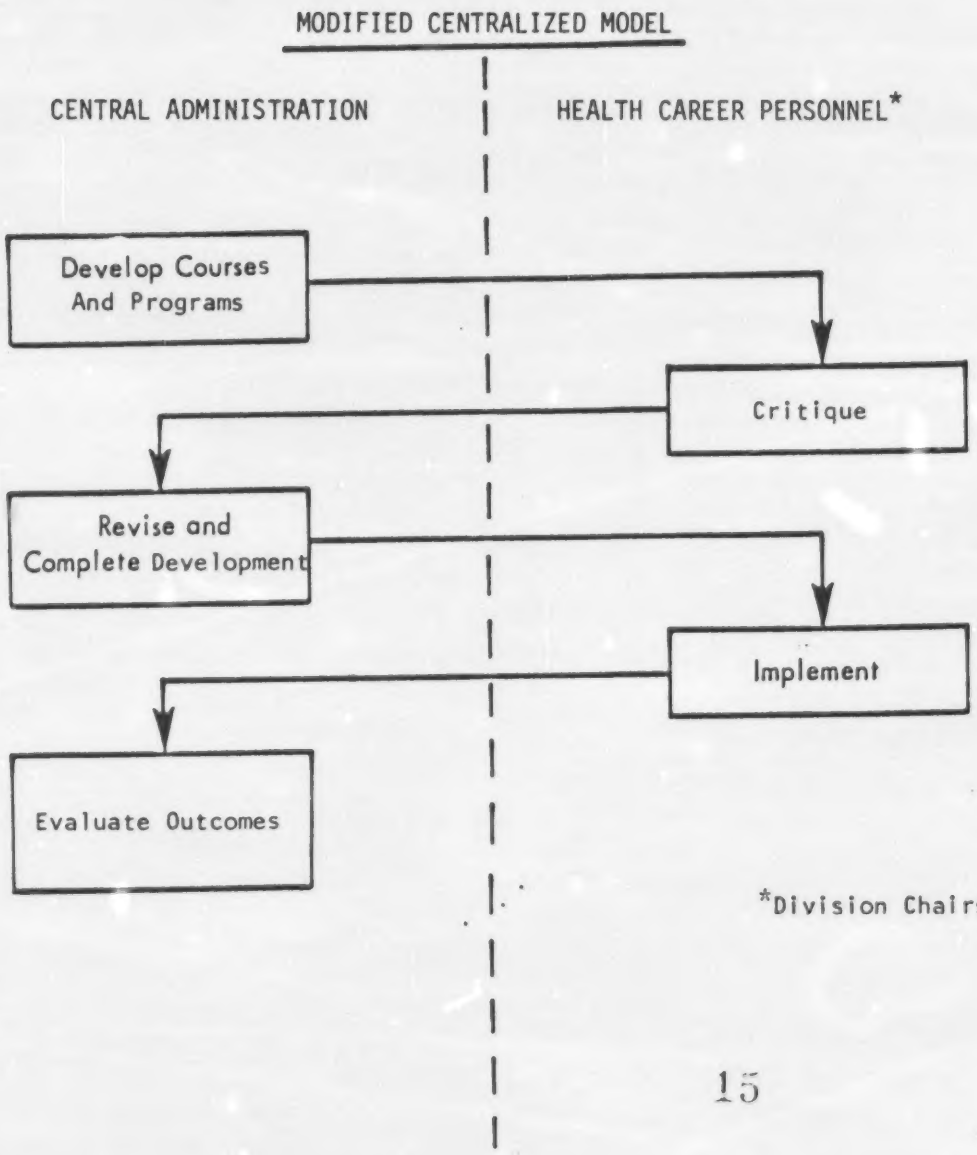
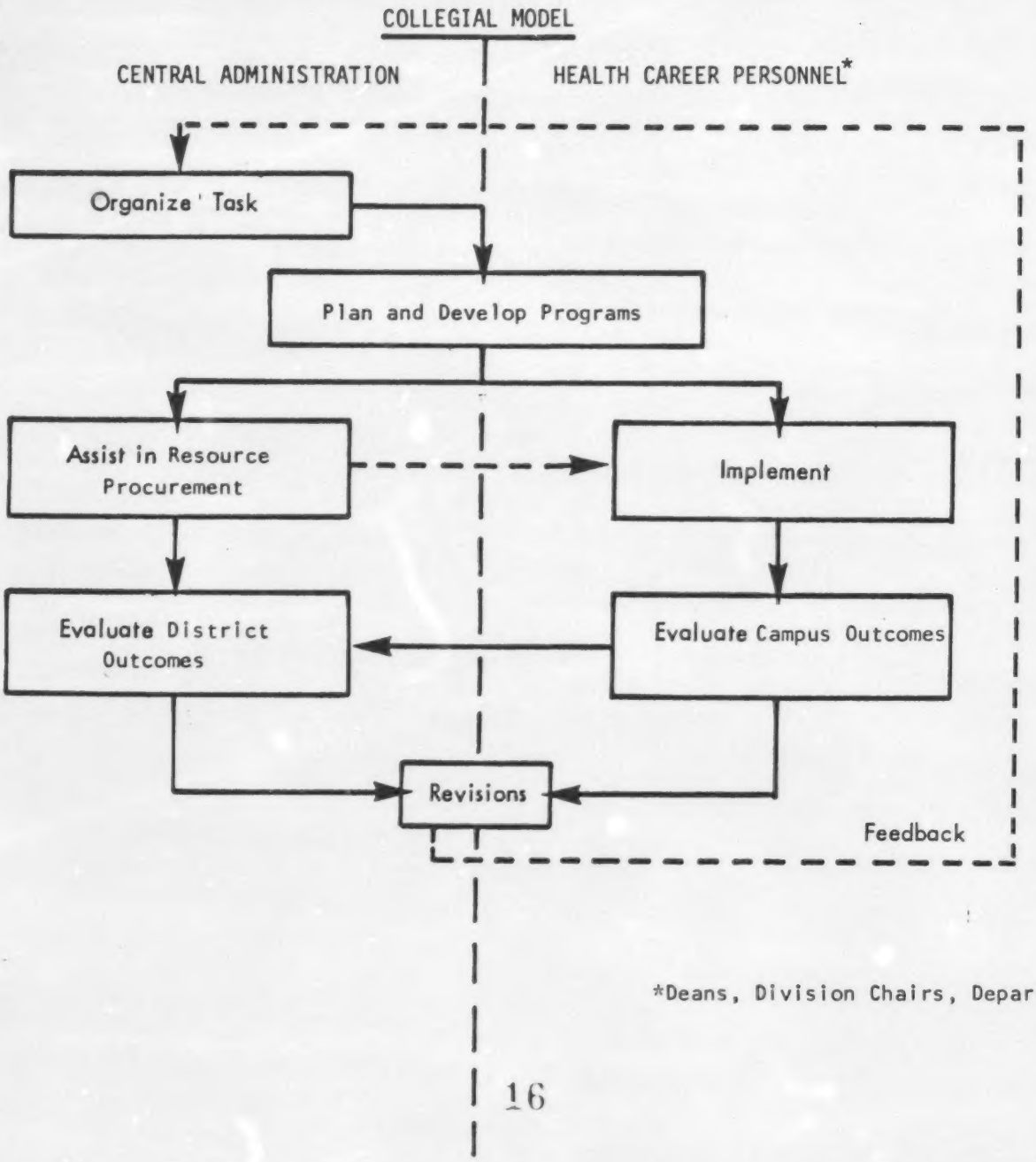

CENTRALIZED MODEL
CENTRAL ADMINISTRATION
HEALTH CAREER PERSONNEL*
Develop Courses and Programs
Implement
Evaluate Outcomes
*Department Chairs

Figure 3



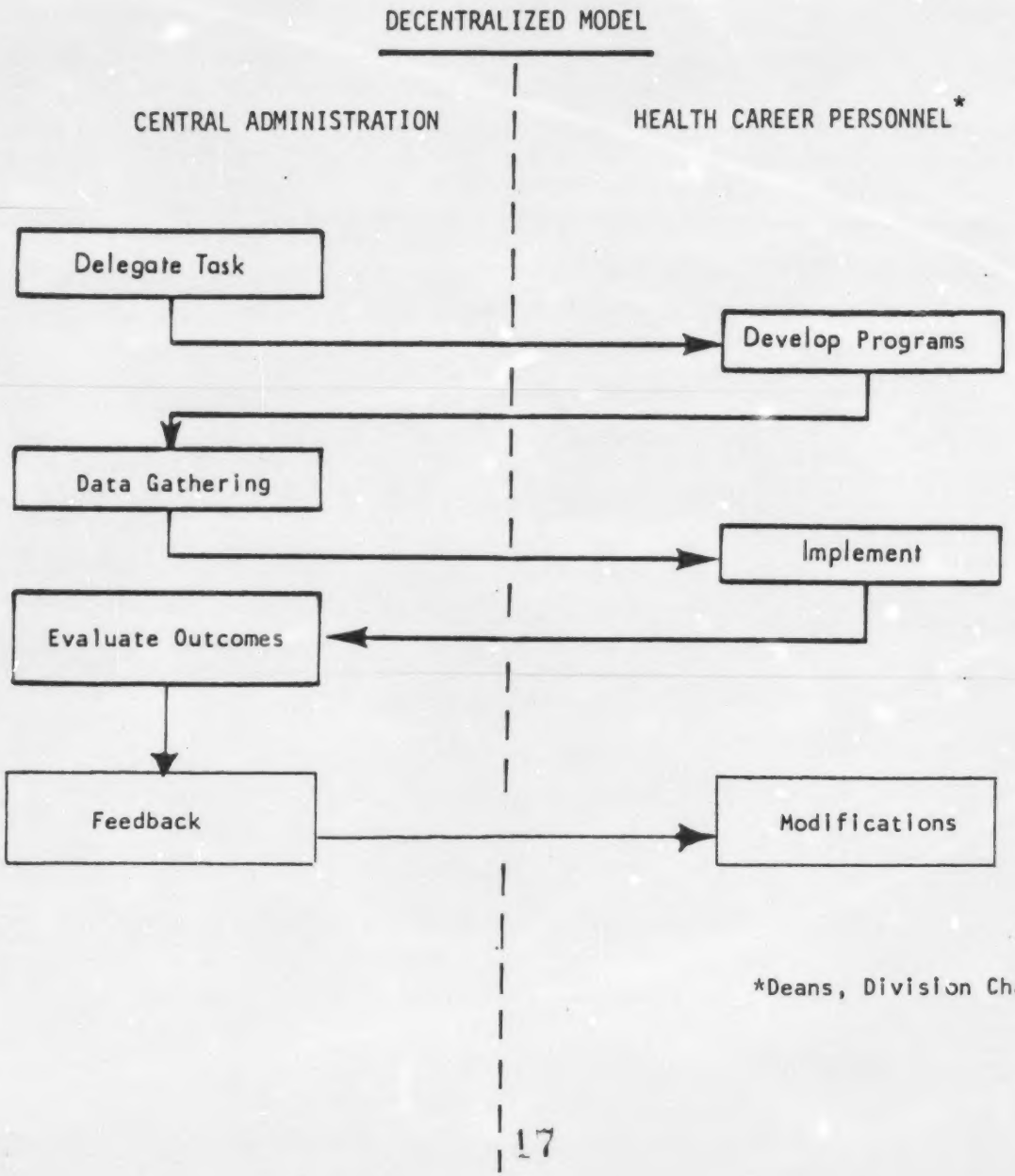
*Division Chairs, Dept. Chairs, etc.

Figure 4



*Deans, Division Chairs, Department Chairs, etc.

Figure 5



*Deans, Division Chairs, Departmental Chairs

*Note (P.5) Appreciation is extended to Dr. Elizabeth Lundgren, Vice President of Miami-Dade's Medical Center, for her comments and suggestions. Dr. Lungren is an excellent resource for Allied Health and Nursing professionals in all areas of management.

*Note (P.7) Mr. Granville Rudy, Dean for Allied Health is an excellent resource for all areas of management.

*Note (P.8) Mr. Max Tadlock, President of Monterey Peninsula College is an excellent resource on not only organizational structures but all aspects of finance and political constraints affecting these programs.

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